Evaluation

Roles

Invest

Retention

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Recruitment

Chapter 5
Implementation plan and agenda for the future

Introduction: A six-year plan for improved public health

The Health Services Act of 1993 requires that the Public Health Improvement Plan include a budget, staffing plan, and implementation schedule to enable the public health system to carry out the core functions of assessment, policy development, and assurance. Protecting and improving the health of communities throughout Washington — the mission of public health and the goal of the PHIP — is dependent on the ability of the system to perform these critical functions.

The act strongly encourages public health agencies, the Washington Health Services Commission, and health plans and providers to work together to improve the health of state residents and communities. By integrating public health and illness and injury care systems into the structure of "health system" reform, the Legislature intends that these entities focus on the same goals (improved access, controlled costs, and improved health), and operate according to consistent rules and incentives. This implementation plan emphasizes early progress in forging these cooperative efforts to improve health status.

The 1994 PHIP calls for a complex strategy of strengthening public health infrastructure. It also calls for developing new and enhancing existing partnerships with health service providers and the community. Community and state-level partnerships will be focused on developing policy, devising prevention strategies, and delivering services. This strategy involves stabilizing and strengthening how public health is financed and governed, critical improvements that will require investment of an additional $104 million per year (1994 dollars) by 2001. In turn, this added investment will allow communities to more successfully prevent disease and injuries, modify unhealthy behaviors, and reduce environmental health threats.

Implementing the 1994 Plan will result in dramatic changes in the structure of the public health system. In order to assure that changes are made effectively, and that the new funds are effectively and efficiently used to make these critical improvements, implementation should be phased in over a six-year period, from July 1995 through June 2001. The new funds should begin with $17.5 million in the first year (1995) and increase annually by that amount over the next five years ($17.5 million, $35 million, $52.5 million, $70 million, $87.5 million and $104 million) until the annual increase is $104 million in 2001. A phase-in is also necessary to allow for adjustments as the complexities of broader health system reform unfold. The need to anticipate and respond to a changing environment also means that public health strategies will need to be adjusted even after 2001, when well-functioning core capacities will have been developed.

National attention on PHIP

The PHIP is generating excitement throughout the national health care community. "The State of Washington is poised to do what the rest of the country has only talking about: underpin health system reform with a strong public health foundation," claimed a front page article in a recent issue of American Medical News, the publication of the American Medical Association.

"Washington State has recognized the central role of public health in health reform," said a local health officer from Michigan. A past president of the National Association of County Health Officers stated, "It (PHIP) can be a model for what can happen in other states or even nationally. All of us in public health will be watching."

Other states, such as Minnesota, Ohio, and Michigan have already undertaken efforts to study and plan reform strategies. From the attention being given the PHIP, it likely will have a significant influence on health system reform outside the boundaries of Washington State.

Thus, the 1994 PHIP and the implementation actions presented in this chapter should be viewed as a "rolling" plan to be revised at least every two years. In fact, the PHIP is required to be revised and submitted to the legislature prior to every biennium. This chapter focuses on the next biennium (1995-97), briefly describing the work the Department of Health, local public health jurisdictions, tribal governments, and state agencies will be undertaking. It also describes the investment necessary to support this work, a framework for evaluating the success of implementation, and key issues that will be addressed in the next Public Health Improvement Plan due to the legislature by December 1, 1996. The following chronological sequence encompasses this Phase of the PHIP:

The 1994 PHIP	The first biennial PHIP, submitted to the Legislature on December 1, 1994, covering the two-year period of July 1, 1995 - June 30, 1997.
1995-97 Budget	Financing for the PHIP implementation activities during the biennial period of July 1, 1995 - June 30, 1997.
The Next PHIP	The second biennial PHIP, submitted to the Legislature on December 1, 1996, covering recommendations for the two-year period of July 1, 1997 - June 30, 1999.

1995-97: Recommendations for action

The 1994 PHIP proposes a number of high priority actions that will begin the implementation of the capacity standards, and finance and governance changes described in Chapters 3 and 4. These actions should begin now.

Collaboration

1. In concert with certified health plans and other health-related community agencies, local public health jurisdictions should take the lead in developing a plan for shared responsibilities, including reporting and follow-up of communicable diseases, ensuring access and quality of public health services, and providing referrals within the local health care system.

2. The State Department of Health should provide, in collaboration with local public health agencies, technical assistance to certified health plans and other community providers to strengthen their ability to prevent disease and promote public health.

3. State and local public health agencies should assist in the development of communication policies and networks among state and local public health jurisdictions and other community health-related agencies and organizations, such as certified health plans, health care providers, community and migrant health centers, regional genetic clinics and school-linked health services.

Public hospital districts and reform

Public hospital districts are special district local governments authorized by Washington law (Chapter 70.44 RCW). Initially authorized in 1945, there are fifty-two public hospital districts (PHDs) in the state, with the great majority of these located in rural areas. Roughly 40% of the hospitals in Washington are owned and operated by public health districts and their elected governing bodies. Hospital districts are authorized to provide a broad range of services beyond hospital care, and these service offerings range across the entire health services continuum.

Collaboration between local public hospital districts and local public health jurisdictions can become an important element of reform. Public hospital districts are involved in working with their communities to fashion and support reform. Many public health districts support the integration of services within communities, but some recognize that some communities may find themselves so remote or small that local autonomy can be achieved only through some degree of regionalization. The local levies for local hospital districts will provide valuable support for non-insured health services (such as health education, senior nutrition programs, and other services important to communities). The public health/public hospital district partnership can be a major asset for strengthening communities across the state.

4. The State Department of Health should collaborate with the Washington Health Services Commission in the design and implementation of a statewide education campaign to inform residents of the services provided by public health and those covered by the uniform benefits package.

5. The State Department of Health should create and implement a program of short-term financial incentives to strengthen coordination and collaboration among local public health jurisdictions and other community based health-related agencies and organizations.

Core function capacity building

6. New state funds for public health should emphasize improving capacity for assessment, health promotion, and access and quality, recognizing that the unique needs of specific jurisdictions may require early investments in policy development and protection.

7. The Department of Health should develop and offer technical assistance to local public health jurisdictions to help them make decisions concerning the provision or assurance of clinical personal health services, and their relation to core function capacity needs. This assistance may include helping local jurisdictions determine whether they are Category A, B, or C, in terms of their ability and desire to meet the capacity standards (see finance and governance recommendations, Chapter 4).

8. The Department of Health should work closely with the local public health jurisdictions to assist them in developing the capacity for community health planning and community mobilization. The 1994 PHIP capacity standards place a strong emphasis on community health planning for public health, and the role of public health in mobilizing the community for public health decision making.

9. The Department of Health should help develop and implement a professional training and educational program to enhance the competencies of the public health work force to perform the core public health functions.

10. The Department and local jurisdictions should participate in the development of the Health Services Information System, a central integrated repository of data on personal and community health that will serve as a resource to local public health jurisdictions and other entities.

Financing

11. The Department of Health should explore ways of minimizing the negative effects of changes in local government public health financing, including a possible short term subsidy to local jurisdictions while it develops other sources of funding. Such a strategy may be needed — depending on the recommendations of the Tri-Association study and subsequent decisions by the Legislature — because the change in the motor vehicle excise tax (MVET) allocation (see finance and governance recommendations, Chapter 4) will have an unequal effect on local public health jurisdictions and cities across the state.

12. The Department of Health should provide financial incentives to local health jurisdictions to encourage collaboration among state and local health jurisdictions and other community-based public health agencies (see definition of Category B jurisdictions, finance and goverance recommendations, Chapter 4).

13. The Department of Health should develop a contract and financial tracking system to provide accountability for contract funds to local health jurisdictions and to determine cost effectiveness of public health investments.

Clinical personal health services transition

14. For the 1995-97 biennium, current public health funds supporting clinical personal health services should remain in the public health system. The reasons for this recommendation include:

- Responsibility as a "safety net" provider during transition: The phase-in of Washington's health reform means that the entire population will not have insurance coverage for the uniform benefits package until 1999. In addition, the state does not yet have congressional authority to implement the employer mandate provisions of the reform law. Therefore, the public health system should continue to be a safety net provider for people who do not yet have coverage and are not eligible for Medicaid and the Basic Health Plan, or are otherwise unable to obtain needed care.
- Synchronization during transition: Successful transition of responsibility for clinical personal health services will require synchronization with the development of certain key components of health reform, including certified health plan standards and quality improvement plans, assessments of health plan enrollee health status, broad-based community wide health assessments, and the Health Services Information System.
- On-going community protection against vaccine-preventable diseases: While the uniform benefits package is intended to cover many immunizations, the phase-in of coverage will leave many individuals (and therefore their communities) unprotected. The public health system should continue to finance and distribute vaccine, and administer some immunizations over the next biennium. As health plans provide greater proportions of immunizations, public health jurisdictions should also develop collaborative arrangements among health plans, public health, child care organizations, and schools to increase access and eliminate barriers to childhood immunization.

- *On-going prevention and control of communicable disease: Clinical personal health services related to communicable diseases — including testing, physical examination, and patient counseling and education — are linked to the population-based public health activities that control the spread of communicable disease (for example, contact tracing, partner notification, and follow up exams and counseling/education related to sexually transmitted diseases). In addition, significant costs may be saved if confidential, accessible clinical service alternatives for sensitive services are available for people who might not seek such services from a primary care provider (e.g., reproductive health services for adolescents, HIV counseling and testing, and sexually transmitted disease treatment and follow-up).*
- *On-going assurance of family planning and reproductive health services: Barriers exist to using family planning and reproductive health services in a regular and timely fashion, especially for youth. These services will be covered in the uniform benefits package and provided through certified health plans. However, communities bear high costs when these services are not used when needed. Therefore, multiple, confidential options for access must exist.*

15. *The Department should work closely with local public health jurisdictions, the Washington Health Services Commission, and certified health plans to monitor the transition of clinical personal health services from public health to private health coverage.*

Legislation

16. *The Department of Health should review the Revised Code of Washington (RCW) and Washington Administrative Code (WAC) to identify the statutes and codes related to public health, and make recommendations about what changes need to occur to implement the next PHIP due December 1, 1996.*

17. *The Department of Health shall evaluate whether or not legislation is necessary to implement the PHIP vision of a new framework for public health in Washington based on the capacity standards.*

Evaluation of the 1994 PHIP implementation

18. *The 1994 Plan should be evaluated as it is implemented, because the Legislature intends it to be a continuous process. The evaluation will help adjust strategies to meet the needs of a changing environment and determine the focus of the succeeding PHIPs. Since the ultimate goal of the PHIP is to protect and improve the health of Washington citizens, the evaluation should involve assessing progress toward the outcome standards discussed in Chapter 3 and presented in*

Appendix A. However, the success of the 1994 PH/P cannot be assessed solely on the basis of health status, because core function capacity will take six years to develop; and there is a lag time between increasing capacity and improving health outcomes. In addition, other providers must also play an active role to achieve improved health outcomes. The evaluation of the 1994 PH/P should include the following:

- The Department of Health and local public health jurisdictions should jointly develop and implement performance criteria to assess progress toward meeting state and local capacity standards and implementing finance and governance changes.
- The Department of Health and local jurisdictions should develop and use state and county level indicators to monitor progress towards achieving outcome standards.
- State and local jurisdictions should evaluate whether to revise: the six-year timeline to bring the public health system up to capacity; the key public health problems, capacity standards, and outcome and threshold standards; and the estimate of increased financing required to bring the public health system up to capacity.
- The Department of Health should monitor the development of collaborative relationships among public health agencies, and evaluate if financial incentives are adequate to increase system efficiency, based on the recommendation in Chapter 4. The Department should evaluate the development of partnerships with community organizations, certified health plans, and health care providers.
- Based on an improved financial accounting system, the Department of Health should oversee the non-supplantation of local government funds, the use of "new" state funds, the level of dedicated financing, and the effects of performance based contracting.

The next Public Health Improvement Plan

19. The Department of Health and local public health jurisdictions, along with their stakeholders and constituencies, should participate in a process for developing the next PH/P. The process should include the following activities:

- The next PH/P should describe the relative responsibilities of the Department of Health and the State Board of Health in meeting the capacity standards assigned to the state in Chapter 3 of the 1994 PH/P.
- The Department of Health and the State Board of Health should determine the need for a single biennial public health document and study matters pertaining to rule-making, policy development, relationships among official public health agencies, and other similar matters of concern, and should make recommendations to the Governor and Legislature.

- The next PHJP should address the relative roles of and the relationships among the State Department of Health, other state executive branch agencies with responsibilities for public health or health activities, and local public health jurisdictions.
- The next PHJP should address the relationship between the state Department of Health and federal public health-related programs, including any waivers that may be needed from the federal Public Health Services Act to fully implement the PHJP. The next Plan should also evaluate the effect of any health system reform legislation enacted by Congress.
- The next PHJP should address relationships and strategies for collaboration among local public health jurisdictions and certified health plans, including local contracting for the delivery of clinical health services and activities to meet capacity standards.
- The next PHJP should continue to refine capacity and outcome standards as needed, including implementing the requirements for standards mandated in the youth violence legislation of 1994 (E2SHB 2319).

1995-97: Investment

To carry out the recommendations presented above, a total of $52.5 million in new state funds should be invested in Washington's public health system for the 1995-97 biennium: $17.5 million for fiscal year 1996 and $35 million for fiscal year 1997. The main purpose of these funds will be to ensure that state and local jurisdictions make significant progress in the 1995-97 biennium toward meeting all the capacity standards by the year 2001. The majority of the funds would go to local health jurisdictions.

Local core function capacity

The PHJP establishes capacity standards to be met by all local health jurisdictions. These standards describe the type of system that must be in place in every community to assure that public health protection is maintained and that the system is capable of providing the information needed for making informed decisions about how to best use public health funds. The plan recommends that additional state funding be made available to local jurisdictions to achieve the capacity standards and address locally identified public health concerns. These funds would be flexible, rather than categorical. Local jurisdictions would be accountable for implementing the plan, achieving capacity standards, and making measurable improvements toward specific health objectives.

Distribution of the flexible local core function capacity funds would be according to a formula that considers some of the factors that affect local needs, including population, variation in assessed property value, a base amount per jurisdiction, and incentives for collaboration.

State core function capacity

New funds for state core function capacity will focus on improving health assessment, health promotion, and service access and quality. There will be some emphasis on development of state and county level health indicator data to measure progress toward outcome standards, plus development of performance criteria related to the capacity standards. Some of the resources will be used to develop the necessary contract and financial tracking system to oversee efficient, effective use of funds, with attention to the effects of performance-based contracting, the level of dedicated financing, and non-supplantation of local funds.

Information systems

Integrated public health information systems are essential for analyzing data, conducting community assessments, evaluating effectiveness of prevention programs, and monitoring progress toward health status goals. New state funds will finance a computer network linking all local public health jurisdictions and the state Department of Health, enabling swift, efficient communication throughout the state. This will assist state and local public health jurisdictions in assessing health status and developing policies for addressing locally identified key public health problems. The new funds will support development and implementation of an integrated data plan for the important but separate systems that now provide critical data for health assessment, including the vital records system, the hospital data system, and several disease reporting systems.

Community Health Assessment and Mobilization

The health assessment process would be carried out in all communities. The scope of these activities would include both an analysis of health status indicators and a review of the community's resources in the public health and health care system. Many communities, however, have almost no capacity for doing a community health assessment. There is no systematic health planning structure in place in the state which might carry out community assessment. All local decisions about how to most effectively deploy public health resources will depend on having accurate information about communities' health-related strengths, weaknesses, and resources.

This process will require a significant amount of staff time and the involvement of many community partners. Maintaining assessment activity over time will require staff and community involvement and is necessary to realize and measure improvements related to public health investments.

Training

The availability and use of community health data are critical to developing public health policy and managing programs. The basic science underlying the collection, analysis, and interpretation of such data is epidemiology. However, there is a nationwide shortage of public health professionals trained in epidemiology, and this shortage is most keenly felt at the state and local level.

This training will be a joint effort of the Department of Health, local health jurisdictions, and state educational institutions. This plan is intended to broaden access to and refine training in the public health core functions, and especially in epidemiology and health assessment activities. It is intended to address three principal areas of need: training and support for state and local professional staff, training of future professionals, and incentives for attracting and retaining professionals.

The first five chapters of this plan have discussed the public health system in Washington and how it might be improved. Chapter 6 offers a case study of how the plan is now being put into action to address one of the major public health problems of our time--youth violence.